STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Village	200 Kingston Cir Ligonier, IN 46767

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37147 Based on observation, interview and record review, the facility failed to ensure fall interventions were followed for 1 of 3 residents reviewed for accidents (Resident J). Findings include: On 7/11/24 at 11:38 A.M., Resident J's record was reviewed. Diagnoses included dementia, Alzheimer's disease with late onset, and generalized anxiety disorder. A quarterly MDS (Minimum Data Set) assessment, dated 5/14/24, indicated the resident had severely impaired cognition with fluctuating behaviors of inattentiveness and disorganized thinking. She had no verbal or physical behaviors and no rejection of care. She required maximal assistance with her activities of daily living. A care plan, revised 7/1/24, indicated Resident J was at risk for falls with a goal of reducing her fall risk factors to avoid significant fall related injuries. An intervention, dated 12/27/2022 was for 2 persons to assist with transfers via the hoyer mechanical lift. A physician order, dated 5/31/24, was for the resident to be transferred with the mechanical lift and assistance of 2 staff members. A Fall Event form, dated 6/27/24 at 9:04 p.m., indicated Resident J had a fall with laceration to the back of her head. The CNA (Certified Nurse Aid) had been transferring the resident with the hoyer lift when the resident became restless and slid out of the hoyer pad. A late entry progress note, dated 6/27/24 at 9:25 p.m., indicated the CNA reported he'd tried to catch the resident from falling to the floor but in doing so, she had hit her head on the bedside table. The resident's wound was assessed and treated and the resident given Tylenol for complaints of a headache. Staff interviews conducted on 7/11/24 were: -11:55 A.M., the PTA (Physical Therapy Assistant) 8, COTA (Certified Occupational Therapy Assistant) 9 and Restorative CNA 10 indicated staff were to have 2 staff members present when transferring residents with the mechanical hoyer lift and stand up lifts. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12:02 P.M., CNA 3 indicated staff were to use 2 staff when transferring residents with the hoyer mechanical lift. They recently completed training on use of mechanical lifts and were reminded in a staff meeting yesterday, 7/10/24, of the importance of using the mechanical lift correctly and with 2 staff for resident safety. -12:40 P.M., CNA 4 indicated they had recently completed training on use of the mechanical lifts and need for 2 staff present when transferring residents for safety. -12:42 P.M., Nurse 6 indicated nurses were to monitor use of mechanical lifts and ensure there was always 2 staff members present when using the lifts. On 7/11/24 at 1:00 P.M., 2 CNA's were observed in Resident J's room with the mechanical hoyer lift and indicated they were going to assist the resident to lay down. They indicated 2 staff had to be present when transferring a resident using the hoyer lift. -At 1:20 P.M., the resident was observed lying on her back in bed with eyes opened. When questioned, she indicated she had no pain from her fall and was alright. On 7/11/24 at 1:39 P.M., the Administrator was interviewed. She indicated, during the facility's fall investigation, the IDT (Interdisciplinary Team) had determined, Resident J had been transferred with the hoyer lift and 1 CNA rather than the required 2 staff members when she slid out of the hoyer lift and bumped her head on the bedside table. The facility's policy required 2 staff members to be present when transferring residents using the mechanical hoyer or stand up lifts. The past non-compliance deficiency began on 6/27/24 and deficient practice corrected on 7/10/24 after the facility in-serviced all CNA's on safe use of mechanical lifts according to the facility's Mechanical Lift skills competency checklist and facility policy which required 2 staff to be present when transferring residents using the lifts; held inservices on 7/10/24 for all staff which included education on the facility policy to use 2 staff when using mechanical lifts; and conducted daily audits to ensure compliance with safe mechanical lift transfers. This tag relates to Complaint IN00436657. 3.1-45(a)